

_____ *Approved*

_____ *Denied*

_____ *Date*

**Medical Exemption Form
2004-2005 Commonwealth Accountability Testing System**

Section 1 – School/District use only. PLEASE PRINT OR TYPE.

A. Exemption for: (Please check the grade appropriate category or categories.)

_____ CTBS

_____ Kentucky Core Content Test

_____ Writing Portfolio

B. Student information

Student's Last Name First MI

Student's Grade Level

District and School Student Attends

Attending District/School Number

Accountable District and School for Student (if different from above)

Accountable District/School Number

Barcode and Lithocode Number from the KCCT Student Test Booklet
(REQUIRED for grades 4, 5, 7, 8, 10, 11 and 12)

Date of Diagnosis/Dates of Hospital Stay

District Assessment Coordinator Signature (REQUIRED)

Date of Request

**Has the student been or is the student
currently on homebound instruction?**
Yes No

Section 2 – Physician use only. PLEASE PRINT OR TYPE. (Attach additional pages if necessary.)

Describe, in detail, this student's medical or mental condition and explain how participation in the state-required assessment would adversely affect his/her physical or mental condition. (Please avoid the use of abbreviations.)

I understand my signature indicates that I believe participation in the state-required assessment would be detrimental to this student's well being.

Print or Type Doctor's Name

Doctor's Signature

Date

Section 3 – I give permission to release my child's pertinent medical information to the school district representative, Kentucky Department of Education and the testing contractor (CTB/McGraw Hill) for the purpose of applying for a medical exemption from the 2005 state-required assessment. I understand that, pursuant to Public Law 104-191, all parties will keep this information confidential.

Parent or Guardian Signature

Date

Note: Completion of this form does not guarantee approval.